Tuesday, July 9, 2013

Ms. Judy Parks
Acting Director
New Mexico Department of Health,
Division of Health Improvement Bureaus & Programs,
Health Facility Licensing & Certification Bureau
2040 S. Pacheco Street
2nd Floor, Suite 421
Santa Fe, New Mexico 87505
Judith.Parks@state.nm.us HAND DELIVERED TO ACTING DIRECTOR'S OFFICE AND VIA EMAIL

Cabinet Secretary Retta Ward, MPH
New Mexico Department of Health
Office Of The Secretary
1190 St. Francis Drive, Suite N4100
P.O. Box 26110
Santa Fe, New Mexico 87502 HAND DELIVERED TO CABINET SECRETARY'S OFFICE

CMS Region 6 Administrator Renard Murray, and
Chief Medical Officer David S. Nilasena MD, MSPH, MS
The Centers for Medicare & Medicaid Services (CMS) - Region 6
CMS Region 6 Administration
1301 Young Street, Suite 714
Dallas, Texas 75202
RODALFM@cms.hhs.gov DELIVERED VIA US MAIL AND EMAIL

Dear Acting Director Parks, Cabinet Secretary Ward, Region 6 Administrator Murray, and Dr. Nilansena,

First of all we thank the New Mexico Department Of Health's Division of Health Improvement Bureaus & Programs, Health Facility Licensing & Certification Bureau for their acknowledgment letter of June 17, 2013, regarding our letter of complaint dated June 10, 2013, and appreciate that the agency will conduct an investigation of our concerns.

To that end, we are submitting the following additional information as an addendum or amendment to the letter we filed requesting that your offices:

1) investigate the matters we bring to your attention in the following narrative (supported by the accompanying documents); and

2) that each of your agencies conduct independent ***surveys to identify any areas that could be dangerous or harmful to the health, safety, or welfare of the patients and staff*** of/at the CHRISTUS St. Vincent Regional Medical Center (CSVRMC) and locally known as St. Vincent's Hospital located in Santa Fe, New Mexico, due to ongoing conditions, procedures and administrative policies; and

3) take appropriate measures to correct any deficiencies or inappropriate procedures and administrative policies in order to meet the objectives of the law that hospital patients receive adequate care and treatment and that the health and safety of patients and hospital employees are protected.

As we pointed out in the June 10th letter nurses and other direct care givers for the past two years "*have communicated their concerns regarding the safety and welfare of patients at the hospital to managers and both Chief Executive Officers/Administrators (for which there have been two individuals, Alex Valdez and Bruce Tassin) and through them to the governing body of CSVRMC.*"

We are including in this amendment further information that was brought to our attention which we feel reinforces the concerns expressed in our original complaint and request for an investigation and the conducting of "*surveys to identify any areas that could be dangerous or harmful to the health, safety, or welfare of the patients and staff of/at the CHRISTUS St. Vincent Regional Medical Center (CSVRMC)*."

In the June 10th letter we presented some examples of insufficiencies health care workers encountered in the delivering of care to their patients. We also presented to your offices several reports entitled "Staffing Insufficiencies Report" and which were attached as EXHIBITS 7 through 10 in the letter.

We have included subsequent "CSVRMC Weekly Staffing Insufficiencies Reports – Dated June 22, June 27, and July 7, 2013," and attached as EXHIBITS 1 through 3, with this letter. This report contains recent comments and concerns of members of the staff at CSVRMC who are charged with direct care for patients at hospital. The concerns have to do with results of not having a sufficient number of personnel to adequately care for the patients at the hospital. Here are a few excerpts (but please review all of the information contained in Exhibit 1):

> *''Comments: OR Nurse Personal Experience - June 20, 2013*
>
> *I am writing this due to my concern regarding the number of hours I had to work non-stop on Tuesday, June 19th. My shift began at 0630 on Tuesday and did not end until 0339 on Wednesday morning. I worked 21 straight hours non-stop except for a 30 minute lunch break at 1130 on Tuesday morning. When I tried to take a dinner break, I was told by Sandy not to clock out, just eat something quickly. Consequently, I did just that without the opportunity to sit and catch my breath or rest. No(t) only is this not healthy for me or any nurse, it is also not the safest situation for the patient …"* [1]

> *5/23/13*
> *Comments: Effects on patients - Report from ER RN: When ER RN was asked about BP meds that were not given, "I don't know if he has had any urine output. We have not had a tech. I don't know which IV he is supposed to have running." The RN could not tell me if, of the 2 running IV orders, which or both were supposed to be running. Pt had not arrived on the floor by 7:30 pm. I called for report at 1810. Pt was dc'd from ER in the computer, but not received on 2200. The patient was allegedly in CT. Who was responsible for this patient?*

[1] **Based upon discussions with nurses this report of working exceedingly long hours in the Operating Room is not an anomaly.**

"The following is an experience this nurse encountered in May, 2013 one morning in the ER:
*It was an "A" shift. The ER was holding about 15 or more admissions and was **short staffed**. My zone ended up with 9 admissions, no tech support, and my partner was a float nurse who had never spent time in the ER and was able to take only the 3 patients with admission orders. My patients were waiting overnight for orders, and one of them had acute intra-abdominal bleeding. She needed fluid boluses to maintain blood pressure. Two others had acute infections and co-morbidities, including diabetes which were not yet addressed. The other three had needs that included skin-at-risk preventive measures, pain, and help with ADLs …"*

Comments: ER Nurse Personal Experience - June 2013
"…Christus/St Vincent Regional Medical Center has of late been striving to become more efficient while providing quality services and care. Part of the effort has been to decrease the nursing AND support staff to 50% and then to 30% of national average staffing levels.

The hospital is also incorporating the latest concepts of professional nursing by attempting to have collaborative leadership teams, and by requiring various competencies that have been shown to effect positive patient outcomes. Our charting must reflect seamless compliance with national standards---all while having an increased patient load and less support staff. (!) …"

5/2012
Comments: Effects on patients: Upon receiving report, found patient being transferred to UNM had not eaten in 3 days and was begging for food. I had to get an order for a regular diet and run to ED for a sandwich as the patient was being shipped out by ambulance.

5/29/13
Comments: Short 1 RN and 1 CNA. Each CNA had 18 patients. At 1100, RN came in to SOS. RN needed assistance with patient. Had call light on for 10 minutes. No one answered due to being short staffed and all staff with busy with other patients.

On this shift, there were 14 discharges out of 38 patients, 7 admissions, and 2 transfers to other units - a very high patient turnover.
Effects on patient: Per CNA: 1. Unable to give enough attention to the needy patients. 2. able to give 3-4 baths out of 18 patients. 3. did not have time to ambulate patients. 4. some 1400 vital signs were not taken. CNA did not have time and RNs were maxed out with their duties. 5. 5 patients were on isolation which greatly increased the CNA workload. 6. 2 patient were incontinent. I patient was frequently incontinent of stool - on the bed, the linens, and tried to get up independently. The patient got stool on the floor. This patient needed multiple cleanings and changes. 7. While 1 CNA took break or lunch, there was NO CNA on 1 side of the unit.

6/8/13
Comments: Short 1 RN. Many patients are high acuity, but staffing remains short 1 RN. I started at 7 am with 6 patients - 2 high acuity, 2 medium acuity and 2 low acuity. One high acuity patient was having respiratory distress and needed immediate attention. Other high acuity patient had frequent neuro checks and urinary retention. This patient was also impulsive, unsteady and got out of bed x2 independently, prompting bed alarm. Respiratory patient required constant monitoring and medicating. Low acuity patient dc'd to home. At 1530 I pick up seemingly low acuity patient, but patient's room air oxygen level was 68%. Patient not compliant with wearing oxygen. MD suspected

pulmonary embolus - needed immediate test and large IV. Then pt. had 5 beat V-tach and required IV magnesium. Then required antibiotics for postop surgery. Now had 3 high acuity patients. All 3 required continued tests, IVs and medications. One low acuity patient was only "eyeballed" to be sure okay without any needs. Luckily, colleague saw my distress and offered to help. Being short 1 RN from 3-7 pm exacerbated the intensity of nursing care required by my patients. If staffing had been appropriate, this almost impossible situation would not have occurred.

[6/18/13: Sustained Ventricular Tachycardia is a fatal arrhythmia that requires immediate defibrillation (shock)]

6/10/13

Comments: Director - we will not cap a unit...meaning: a unit will continue to take patients in spite of any staffing shortages.

DAY/DATE	UNIT/AREA	SHIFT	PATIENT CENSUS	#REQUIRED STAFF				ACTUAL # OF STAFF WORKING
6/19/13	2100	night	33		CN	7	CN	7
				NA	3	NA	2	
				Secr.	1	Secr.	1	
				Sitter	1	Sitter	1	

Comments: Short 1 CNA. Each CNA had 15 and 16 patients.

DAY/DATE	UNIT/AREA	SHIFT	PATIENT CENSUS	#REQUIRED STAFF				ACTUAL # OF STAFF WORKING
6/20/13	2100	night	35		CN	7	CN	7
				NA	3	NA	2	
				Secr.	1	Secr.	1	
				Sitter	1	Sitter	1	

Comments: Short 1 CNA. Each CNA had 16 and 17 patients. Per CNA, very difficult to take care of all of these patients' needs.

DAY/DATE	UNIT/AREA	SHIFT	PATIENT CENSUS	#REQUIRED STAFF				ACTUAL # OF STAFF WORKING
6/16/13	IP Rehab	night	14		CN	3		CN 3
				NA	(1.5) 2	NA	0	
				Secr.		Secr.		
				Sitter	1	Sitter	1	

Comments: No help on the floor. **No CNA.**

DAY/DATE	UNIT/AREA	SHIFT	PATIENT CENSUS	#REQUIRED STAFF		ACTUAL # OF STAFF WORKING	
6/22/201	PEDS/med.-surg	night	5	CN	3	CN	2
				NA	0	NA	0
				Tech	1	Tech	0
				Sitter	1	Sitter	1

Comments: PEDS was closed and 3300E had 4 patients with 2 RNs and a sitter. One RN was floated to Rehab. This is plenty of staff until 0530 when we got a call to open PEDS and accept a baby in distress from 3600. Once we have a distressed baby we NEED 2 RNs for that baby. We did finally get our floated RN back, but that took 15 min of phone calls to the House sup. and staffing. In the meantime I was able to get the 3600 RN to stay and help me until we got our RN back. We have been over this with the DON and managers. If we have a low census on our unit, the RN we float off should go ***as an SOS RN and not have a patient load*** *some where else so that she can return immediately. Our previous manager and the DON have said that on PEDS we should have 2 RNs at all times but also said that they won't put anything in writing because then if that standard is not provided CSVRMC can be held responsible by joint commission.*

[This one is a big deal too. DOH should be aware why every unit should have at least 2 RNs on duty no matter how low the census is. If there was a sudden emergency (as every hospitalized pt is at increased risk for), we need at least 2 licensed people to deliver life-saving care. This is a hospital and it is expected that immediate life-saving care would be given if needed. The other thing here is of course, what happens to the other unit when the Peds RN who floated there immediately has to leave and go back to Peds? All the nurses take on at least one more patient, that's what. Also, it is extremely disorienting and stressful to be working in one environment and in one rhythm only to get yanked back and thrown into an emergency

6/16/2013

Comments: Effects on patient: Family member was told there would be a family conference at 1PM. At 3PM she asked about the conference. I called multiple providers including hospitalist, surgeon, the surgery PA to learn if the patient would be going to surgery or if he could start on a diet. There was either no response or no definite answer for multiple hours. The patient wanted oral nutrition, was refusing surgery and was becoming increasingly agitated. By 6PM I still had no answers for the family member nor the patient.

DAY/DATE	UNIT/AREA	SHIFT	PATIENT CENSUS	#REQUIRED STAFF		ACTUAL # OF STAFF WORKING	
6/27/13	3200	day	30	CN	7	CN	5
				NA	3	NA	2
				Secr.	1	Secr.	1
				Sitter	2	Sitter	0

Comments: "We have people that fall, get break down because one person CNA cannot properly care for 15 patients. Vital signs are vital, and we can't even get those because it takes 2 hours to get all 15 patients' vital signs. Q2 (every 2 hour) turns are rarely done due to the fact that nurses and CNA's cannot do all the

work that is required from us. When I did complaint the manager told me (that) not to give my patients baths because vitals are more important. So is skin, I thought. There's too much wrong on our floor. It's to the point where I and my coworkers dread work.

Comments: 1700 - I am an RN that had clocked out. I was leaving when the nursing assistant came to get me to say the nurse of 2112B needed my help. I ran to the room. The patient had a high fever and was difficult to arouse. I called the charge nurse and let the phone ring 20+ times. I called twice - no answer. I called the hospitalist. She responded. She ordered narcan 0.4 IV which was given. No change in responsiveness. Vitals done. Rapid Response called. <u>The issue is, lack of support, in a crisis. Nursing is a team sport, and one nurse should not feel the extreme pressure of a crashing patient with no clinical supervisor support or other nurses around to assist immediately in a crisis.</u>

7/6/13 2100 3pm-7pm

Comments: My patient acuity was high for 2 patients. Another patient was non-compliant with non-weight bearing status after a surgery on his foot with a wound vac in place. Another patient was an IV drug user who had made phone arrangements to meet someone at the hospital to bring him drugs. This was reported by the wife of the patient's roommate to the clinical supervisor. The IV drug user patient was told not to go off of the unit. During a Rapid Response Team call on another of my patients and at the same time a continuous bladder irrigation emergency on another of my patients, the IV drug user patient was not in his room. After both previous emergencies were under control, I went to the front entrance of the hospital and found the IV drug user patient almost outside. I needed to call security as the patient would not return to his room. ***<u>Because my patient acuity was high relative to the above mentioned patients, this was an extremely difficult four hours to provide safe patient care, to cover two patient emergencies, and to return a drug risk patient to his room. The hospital should be using an acuity tool for RN assignments to comply with the Nurse Staffing Plan, the RN contract, and the DOH regulations. I had to stay 1.5 hours overtime due to the high acuity of my patients and their care required. One of the emergency patients was transferred to PCU at 2000 by me. The clinical supervisor was also 1.5 hours overtime to complete her tasks related to the acuity of patients.</u>***

The examples above are a reflection of the intense pressure nurses, CNA's and other direct health care givers are experiencing practically every day at CSVRMC.

This pressure is created by the actual staffing which does NOT reflect the acuity of patients, despite CSVRMC having adopted a Nurse Staffing Plan that requires that patient acuity be a significant component in the determination and execution of nurse and supportive staffing for the care of patients.

This unnecessary pressure in theirs and our professional opinions contributes to the violation of the intent of Title 7 of the NMAC to "*<u>ensure that hospital patients receive adequate care and treatment and that the health and safety of patients and hospital employees are protected</u>*."

What is even more disturbing is the apparent disregard by CSVRMC for the New Mexico statutes and regulations relative to safe staffing measures.

The examples referred to above fly in the face of the provisions of Title 7 (HEALTH), Chapter 7 (HOSPITALS) , Part 2 (REQUIREMENTS FOR ACUTE CARE, LIMITED SERVICES AND SPECIAL HOSPITALS, specifically section:

7.7.2.27 NURSING SERVICES:

D. Patient Care.

(1) Care planning:

(a) All nursing care shall be planned and directed by professional registered nurses. A professional registered nurse shall be on duty and immediately available to give direct patient care when needed.

(b) A professional registered nurse shall be available at all times to render direct care in the facility.

(2) Care determinants:

(a) A professional registered nurse shall assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the preparation and competence of the available nursing staff.

(b) The ratio of licensed nursing personnel to patients shall be determined by the acuity of patients, the patient census, and complexity of care that must be provided.

As an added measure of support to our concerns about the dangerous nature of insufficient staffing at CSVRMC we refer you to a Special Article of the New England Journal OF Medicine, entitled *Nurse Staffing and Inpatient Hospital Mortality*, dated March 17, 2011, (N Engl J Med 2011; 364: 1037-1045 | March 17, 2011.

In that article, researchers Jack Needleman, Ph.D., Peter Buerhaus, Ph.D., R.N., V. Shane Pankratz, Ph.D., Cynthia L. Leibson, PhD., Susanna R. Stevens, M.S., and Marcelline Harris, Ph.D., R.N., conclude:

> "… There was a significant association between increased mortality and increased exposure to unit shifts during which staffing by RNs was 8 hours or more below the target level (hazard ratio per shift 8 hours or more below target, 1.02; 95% confidence interval [CI], 1.01 to 1.03; P<0.001). The association between increased mortality and high patient turnover was also significant (hazard ratio per high-turnover shift, 1.04; 95% CI, 1.02 to 1.06; P<0.001).
>
> In this retrospective observational study, staffing of RN's below target levels was associated with increased mortality, which reinforces the need to match staffing with patients' needs for nursing care. (Funded by the Agency for Healthcare Research and Quality.)"

Some Additional Observations

For the past three weeks we have been meeting with and providing nurses, techs, and CNA's an opportunity to candidly express their concerns. Their concerns are not about compensation.

They are worried that the culture of staffing to an arbitrary percentile developed by CSVRMC is placing patients and staff in dangerous situations, and certainly inhibiting the delivering of the proper care patients of Northern New Mexico are entitled to.

(*And as stated in the June 10th letter, they are concerned that the Nursing Administrators are not following the Nurse Staffing Plan which was developed by the hospital's Nurse Staffing Committee. If you care to review the expressions of concern provided to CSVRMC's Chief Nursing Officer by the direct care nurses at the monthly meetings of the Nurse Staffing Committee, we can provide you with a recording of some of those meetings*.)

During the discussions of the past three weeks additional instances of profound concern were raised. Here are a few samples of the complaints and concerns these nursing professionals have brought forward:

1. Telemetry Incident PCU

Tele techs called and called for someone to check a patient on PCU. Roommate's family noticed staff attempting to readjust equipment. Finally while one tele tech was on the phone attempting to call PCU again the other tele tech called the clinical supervisor. The CE, went out to check patient and found the patient had died. The primary nurse who was also the charge nurse remarked, "I know, I know I am just going in there with the meds" The CS then informed the RN "the patient in dead". This incident may have occurred late 2012 or early 2013.

ANOTHER RECENT TELEMETRY EXPERIENCE:

6/2013 CCU telemetry monitoring

Comments: We watch 48 patients on telemetry per 1 tech. That number is steady and sometimes we are unable to keep up with all the phone calls coming in and going out. There is not enough staff on the floor to fix telemetry problems, answer the phone when we call, check on patients. When we do get a hold of someone on the floor or even help us get a person on the other side (21E to 21W). Just on one patient it takes us up to 2-4 hours to get someone to fix the leads or place the patient back on telemetry after a shower. We call constantly, and problems are not being fixed. I fear that I won't be able to get help for patients who are in danger because we can't reach the floor. Everyone is so busy that they don't even call telemetry when the patient has moved into another room or unit. So, calling a CRT (critical response team) might not help if we have a wrong room number.

This place has become an unsafe environment for patients and staff. Nurses are at constant risk of losing their licenses. I would not bring anyone in my family here because I know there is not enough staff to take good care of my loved ones. :(Patients are not safe here anymore.

6/2013 CCU telemetry monitoring

Comments: **I have watched more than 48 people on telemetry at once.** The greatest fear for telemetry is not having anyone answer the phone when a patient has a problem with their heart rhythm. We are able to call a code from the telemetry room if necessary, but that could have been avoided if the patient's nurse had been aware of the situation earlier.

2. **Unexpected death, young woman 2100 - This 40ish year old woman** had had a low potassium which was over corrected, Allegedly she died from a lethally high potassium level. It is our belief there was a root cause analysis of this incident.

[*We encourage you to confirm this incident and investigate it thoroughly; the nursing professionals feel this type of outcome is directly related to the sub-standard level of staffing at CSVRMC, and is further complicated because of the failure of the hospital administration to comply with its own Nurse Staffing Plan.*]

3. Patient who eloped, found in parking lot suffering a heart attack, brought back into hospital for further treatment.

[We are concerned that this is not an exception to the rule so to speak. Not having appropriate staffing by nurses and other professional care givers leads to these situations, and we have received information from discussions with staff that indicate a culture of intimidation as to reporting these types of events occurring.]

4. Fall, head bleed, death on 3200 sentinel event follow up with root cause analysis 2012.

[As stated in the account (numbered 2, above) of the unexpected death of a young woman, this type of event may be related to inadequate staffing.]

5. RN needed to float to ER. MY turn, according to float rotation. I have never worked or been oriented to ER. Told CS that I would go to be a tech, but not take a patient assignment (that was the intent/need). Rn that haf taken Firstnet class was told tI float to ER even though it was not her turn and she too had not been oriented to ER. Situation caused a great deal of staff conflict/dissatisfaction over unsafe assignments and lack of following float ing practice. All nurses involved hesitant to notify manager for fear of "getting into trouble.

[This is another example of staff being concerned that a culture of intimidation exists when it comes to questioning a breakdown in proper care being given.]

SUMMATION OF CONCERNS AND REQUESTS FOR EXPANDED REVIEW OF CSVRMC POLICIES AND EXECUTION OF NURSE STAFFING PLAN

Due to the nature of these incidents, we request that your agencies review and conduct appropriate and thorough investigations of each of these alleged events, and all the sentinel events root cause analyses over the past two years.

We want to remind your offices that CSVRMC is the only hospital available to a large segment of the greater Santa Fe community. And while those affluent enough may arrange medical treatment at hospitals many miles away, such options do not exist for so many others. Your offices need to step in and thoroughly investigate the concerns we have brought to your attention.

We are aware that the administration of CSVRMC has in the past three weeks stepped up efforts to perhaps make a good presentation to regulators and the general public.

We have heard rumors about the CHRISTUS corporate folks in Texas arriving to conduct a simulated 'Joint Commission' type of inspection. While we think this is long overdue, we welcome their attention if that is actually taking place with the intent of correcting insufficiencies in staffing and care.

But as we all know many large institutions are reticent to acknowledge problems. That is where the public relies on the independent assessment by offices such as yours in assuring the best protections for those who are in need of medical treatment.

As an aside, but of considerable concern to us, is our knowledge that CSVRMC has recently engaged the services of a politically very well connected person to assist them in community matters. This individual was for years employed by a recently retired United States Senator. We are also aware of the close family and political ties of the previous CEO of CSVRMC (who still is in the employ of the CHRISTUS corporate entity) to the New Mexico Governor's office.

Between these two individuals we understand that they have both sides of the political aisles, so to speak, covered as far as communicating to government officials.

While we respect that your agencies operate in a manner that is to be free from 'political' influence, we want to express our concern that should there be any effort by CSVRMC to have these individuals intervene through political channels in any way that it be done so with transparency.

The laws of the federal and state government provide the public access to communications relative to the public business and we intend to exercise such access through the United States Freedom of Information Act and the New Mexico Inspection of Public Records Act. (See attached as Exhibits 2 and 3, requests to inspect public documents and communications.)

Therefore we restate our request for your independent investigation into our concerns regarding the performance of CSVRMC in delivering patient care over the past two years and to conduct surveys of the day to day practices and activities currently performed at CSVRMC in the delivering of patient care.

We also want to make a very specific request to look at all Sentinel Events (as defined by The Joint Commission), reported by CSVRMC or not, and to do a thorough examination of all the Root Cause Analysis of events that have or should have been conducted.

As stated above we are providing additional documentation (see attached exhibits) which supports our concerns and the request for action on your agencies' part.

I also wanted to again address the issue of the loss of experienced nursing personnel and the negative impact it has on the delivery of health care in Northern New Mexico's primary hospital. In our letter of June 10th, we wrote: "*The result of inaction by CSVRMC towards the concerns of nurses and supportive staff has led to a massive exodus from our community hospital of experienced nurses, who have dedicated many years of their lives to the care of their neighbors and friends*."

At the time we wrote that sentence we had not confirmed the actual number of nurses (most with many years of experience in the practice of nursing) we have lost due to their frustration with CSVRMC's short staffing policies.

That number is in excess of 182, and unfortunately still growing.

This should be of grave concern to all of us, including CMS and the New Mexico Department of Health.

Who is going to train the new nurses who are beginning their journey to providing thoughtful and thorough care for their patients?

Adding more travelers to the everyday routine of CSVRMC's hospital care giving is not an acceptable manner to develop and keep a dedicated and focused team of nurses, technicians, and nursing assistants which is also familiar with the needs of our community.

Let me leave you with this quote from the American Association of Critical Care Nurses:

"Inappropriate staffing is one of the most harmful threats to patient safety and to the well-being of nurses."

Thanking you for your prompt attention to this letter and its requests for action, and on behalf of the nurses and supportive staff at CSVRMC whom we represent, I remain

Sincerely yours,

Fonda Osborn, President
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Cc – CEO Bruce Tassin (with a cover letter requesting that he forward a copy of same to the governing board of CSVRMC)